Retiree Benefits

Open Enrollment 2011

Effective: 1/1/2011 - 12/31/2011

MEA/MEO/NA

If you (and/or your dependent) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 13-14 for details.

SUMMARY

The information in this brochure is a general outline of the benefits offered under the City of Huntington Beach's benefits program. Specific details and plan limitations are provided in the Evidence of Coverage (EOC), which is based on the official Plan Documents that may include policies, contracts and plan procedures.

The EOC and Plan Documents contain all the specific provisions of the plans. In the event that information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

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RETIREE BENEFITS PROGRAM 1/1/2011 THRU 12/31/2011

INTRODUCTION

The City of Huntington Beach takes pride in offering a Benefit Program that provides flexibility for the diverse and changing needs of our employees and retirees. The City offers employees and retirees and their family members a full range of benefits including:

- Medical HMO Plans
- Medical PPO Plans
- Dental HMO Plan
- Dental PPO Plan
- Vision Plan

The City's Blue Shield medical plans will continue to be administered through CSAC-EIA. There will be slight changes to the current Blue Shield HMO (impacting ER co-pays and Rx) and PPO plans (impacting Calendar Year deductibles and Rx). Blue Shield HMO pharmacy benefits will continue through Blue Shield and Blue Shield PPO pharmacy benefits will continue to be administered by Medco. Kaiser HMO benefits will remain in place and will not be a part of the CSAC EIA-Health Program.

The Human Resources Department has taken many steps in providing easy access to health and benefit plan information. Please visit the City's internet site at www.surfcity-hb.org/retiree_benefits.

If you have any questions, please do not hesitate to call our Employee Benefits Team:
Barbara Pratt, Personnel Assistant, (714) 375-8456
Jaymie Liu, Human Resources Analyst, (714) 536-5213 or
Brigitte Charles, Principal Human Resources Analyst, (714) 536-5917

Sincerely,

Michele S. Carr
Director of Human Resources

WHAT YOU NEED TO KNOW

Human Resources would like to take this opportunity to give you important information about the benefits being offered by the City of Huntington Beach for the 2011 calendar year. It is important that you use the following information to educate yourself about the open enrollment process, timeline and changes.

What can I do at this year's Open Enrollment?

City of Huntington Beach benefit-eligible retirees can:

- Make changes to Medical, Dental, and Vision Plans
- Add or delete dependents
- Switch to a different Medical or Dental plan

What do I have to do if I am NOT making changes?

- Even if you are not making any changes, you need to indicate "no changes" on your benefits summary for 2011 (Benefits at a glance) and verify the accuracy of personal data, especially social security numbers for dependents.

How do I participate in Open Enrollment?

- Submit all changes **via a hard copy of your benefits summary to Human Resources.** Your benefit elections will be effective January 1, 2011. **All changes must be received by Human Resources no later than 5:00 p.m. on Friday, November 5, 2010.**

What if I have questions or need assistance?

- Call or e-mail:
  Barbara Pratt at (714) 375-8456, bpratt@surfcity-hb.org
  Jaymie Liu at (714) 536-5213, jaymie.liu@surfcity-hb.org
  Brigitte Charles at (714) 536-5917, bcharles@surfcity-hb.org

  Note: Employee benefits staff are available for enrollment assistance.

WHAT YOU NEED TO KNOW (Con't)

What if I want to make changes throughout the year?

- You can only make changes outside of Open Enrollment if you have a Qualifying Event.

  To add dependents you have **31 days** from the Qualifying Event to submit an "Add Dependent" form to Human Resources. The Qualifying Event could be marriage, birth, adoption, a dependent becoming eligible, spouse losing coverage, etc.

- You are required to submit a "Delete Dependent" form to Human Resources within 60 days of a dependent becoming ineligible such as divorce, an overage dependent no longer eligible, etc. **Failure to do so can jeopardize your COBRA rights.**

WHAT WILL HAPPEN ON JANUARY 1, 2011

What will be the same on January 1, 2011?

- Benefit Carriers for all plans will remain the same.
- The maximum age for dependents (non-students) on the dental and vision plans will remain at age 25. Note: The maximum age for dependents on the medical plans will be extended up to age 26 due to health care reform (see page 11 for additional information)

What will change on January 1, 2011?

- See enclosed rate sheet for 2011 premiums.

The following changes will occur as part of the Health Care Reform effective January 1, 2011:

- Extend dependent eligibility to age 26 for medical plan coverage only regardless of student or marital status. This does not extend to spouses or children of such dependents. See page 9 for more details.
- Elimination of lifetime limits and restrictive annual limits on the dollar amount of essential health benefits.
- Elimination of pre-existing conditions for children under 19.
- Preventive care on Blue Shield HMO and PPO health plans will be covered at 100% without cost sharing.

MEDICAL PLAN FEATURES

	HMO OPTIONS SCHEDULE OF BENEFITS	
PLAN BENEFITS	**BLUE SHIELD HMO**	**KAISER HMO**
OFFICE VISITS	$15 Copay $30 Copay for self-referred specialist consultation	$15 Copay
PRESCRIPTION DRUG (must use a participating retail pharmacy)	(up to a 30-day supply) $10 Generic $25 Brand $45 Non-Formulary	(30-day supply) $10 Generic $20 Brand
PRESCRIPTION DRUG - MAIL ORDER*	(up to a 90-day supply)* $20 Generic $50 Brand $90 Non-Formulary	(100-day supply) $20 Generic $40 Brand
EMERGENCY SERVICES	$150 Copay (waived if admitted)	$100 Copay (waived if admitted)
DEDUCTIBLE	None	None
MAXIMUM OUT-OF-POCKET Individual Family	 $1,000 $2,000	 $1,500 $3,000
LIFETIME MAXIMUM	Unlimited	Unlimited
ROUTINE PHYSICAL EXAMS	No Charge	$15 Copay
CHIROPRACTIC	Not Covered	$10 Copay (30 visits/calendar year)
VISION EXAM	No Charge	$15 Copay ($150 hardware allowance/24 months)
HOSPITAL SERVICES Inpatient Outpatient	 $100/Admit No Charge	 No Charge $15 per procedure
OUTPATIENT LAB & X-RAY	No Charge	No Charge
SUBSTANCE ABUSE PROGRAM Inpatient Outpatient	 $100/Admit (detox only) $15 Copay	 No Charge (detox only) $15 Copay individual / $5 group
MENTAL HEALTH Inpatient Outpatient	 $100/Admit $15 Copay	 No Charge $15 Copay individual / $7 group

*For Blue Shield PrimeMail information, visit www.blueshieldca.com.

The information in this summary is not intended to take the place of, or change the official Plan Documents or Evidence of Coverage. In the event that the information in this brochure differs from the Plan Document, the Plan Document shall prevail.

MEDICAL PLAN FEATURES

	BLUE SHIELD PPO PLAN	
	IN-NETWORK	OUT-OF-NETWORK
PLAN BENEFITS		
OFFICE VISITS	$25 Copay	40%
PRESCRIPTION DRUG (Medco)* (up to a 30-day supply)	$10 Generic $20 Brand (**$100 brand deductible per member**) $50 Non-Formulary	Plan pays 100% of the allowable amount. Member pays copay (below), plus charges above allowable amount. $10 Generic $20 Brand (**$100 brand deductible per member**) $50 Non-Formulary
PRESCRIPTION DRUG (Medco)* MAIL ORDER (up to a 90-day supply)	$20 Generic $40 Brand (**$100 brand deductible per member**) $100 Non-Formulary	Not covered
EMERGENCY SERVICES	$100 / Visit + 20% ($100 deductible waived if admitted)	
DEDUCTIBLE Individual Family	 $750 $1,500	 $1,000 $2,000
MAXIMUM OUT-OF-POCKET Individual Family	 $3,000 $6,000	 $10,000 $20,000
LIFETIME MAXIMUM	Unlimited	
DURABLE MEDICAL EQUIPMENT	20%	40%
CHIROPRACTIC	20% (15 visits per year combined with acupuncture)	40%
HOSPITAL SERVICES Inpatient Outpatient	 20% 20%	 40% (Max $600/day) 40% (Max $350/day)
OUTPATIENT LAB & X-RAY	$25/visit	40%
SUBSTANCE ABUSE PROGRAM Inpatient Outpatient	 20% $25/visit	 40% (Max $600/day) 40%
MENTAL HEALTH Inpatient Outpatient	 20% $25/visit	 40% (Max $600/day) 40%

*For Medco information, visit www.Medco.com.

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MEDICAL PLAN FEATURES

	BLUE SHIELD MEDICARE COB PLAN	
	PPO IN-NETWORK	NON-PPO OUT-OF-NETWORK
PLAN BENEFITS		
OFFICE VISITS	No Charge	40%
PRESCRIPTION DRUG (Medco)* (30-day supply)	$5 Generic $15 Brand $45 Non-Formulary	Plan pays 100% of the allowable amount. Member pays copay (below), plus charges above allowable amount. $5 Generic $15 Brand $45 Non-Formulary
PRESCRIPTION DRUG (Medco)* MAIL ORDER (90-day supply)	$10 Generic $25 Brand $90 Non-Formulary	Not Covered
EMERGENCY SERVICES	No Charge	
DEDUCTIBLE Individual Family	N/A	$500 $1,000
MAXIMUM OUT-OF-POCKET Individual Family	$2,000 $4,000	$10,000 $20,000
LIFETIME MAXIMUM	Unlimited	
DURABLE MEDICAL EQUIPMENT	No Charge	40%
CHIROPRACTIC & ACCUPUNCTURE (Up to 20 visits, combined, per calendar year)	No Charge	40%
HOSPITAL SERVICES Inpatient Outpatient	No Charge No Charge	40% (Max $600/day) 40% (Max $350/day)
OUTPATIENT LAB & X-RAY	No Charge	40%
SUBSTANCE ABUSE PROGRAM Inpatient (For medical acute detoxification) Outpatient	No Charge No Charge	40% (Max $600/day) 40%
MENTAL HEALTH Inpatient Outpatient	No Charge No Charge	40% (Max $600/day) 40%

*For Medco information, visit www.Medco.com.

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MEDICAL PLAN FEATURES

	KAISER SENIOR ADVANTAGE
	KAISER HMO
PLAN BENEFITS	
OFFICE VISITS	$15 Copay
PRESCRIPTION DRUG (must use a participating retail pharmacy)	(30-day supply) $10 Generic $20 Brand
PRESCRIPTION DRUG - MAIL ORDER*	(100-day supply) $20 Generic $40 Brand
EMERGENCY SERVICES	$50 Copay (waived if admitted)
DEDUCTIBLE	None
MAXIMUM OUT-OF-POCKET Individual Family	 $1,500 $3,000
LIFETIME MAXIMUM	Unlimited
ROUTINE PHYSICAL EXAMS	$15 Copay
CHIROPRACTIC	$10 Copay (30 visits/calendar year)
VISION EXAM	$15 Copay ($150 hardware allowance/24 months)
HOSPITAL SERVICES Inpatient Outpatient	 No Charge $15 per procedure
OUTPATIENT LAB & X-RAY	No Charge
SUBSTANCE ABUSE PROGRAM Inpatient Outpatient	 No Charge (detox only) $15 Copay individual / $5 group
MENTAL HEALTH Inpatient Outpatient	 No Charge $15 Copay individual / $7 group

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DENTAL PLAN FEATURES

	DELTA DENTAL DENTAL PPO			DELTA DENTAL DENTAL HMO
	IN-NETWORK	OUT-OF-NETWORK		IN-NETWORK ONLY
PLAN BENEFITS	PPO DENTISTS	NON-PPO DELTA DENTISTS	NON-DELTA DENTISTS	
ANNUAL MAXIMUM	$2,000 max. benefit			Unlimited
DEDUCTIBLE Individual Family	$25 per person / $75 per family			None
PREVENTIVE Exams X-Rays Cleanings Fluoride Treatment Space Maintainers	85% of PPO dentist's allowed fee (no deductible applies for these services)	85% of Delta dentist's allowed fee		No Charge
BASIC SERVICES Basic Restorative Endodontics Periodontics Sealants Simple Extractions	85% of PPO dentist's allowed fee	85% of Delta dentist's allowed fee		No Charge
MAJOR SERVICES				
Inlays, Onlays, Crowns	85% of PPO dentist's allowed fee	85% of Delta dentist's allowed fee		No Charge
Prosthodontics	60% of PPO dentist's allowed fee	60% of Delta dentist's allowed fee		No Charge
Implants	60% of PPO dentist's allowed fee	60% of Delta dentist's allowed fee		Not Applicable
ORTHODONTIA	60% of PPO dentist's allowed fee (subject to $3000 lifetime max per person)	60% of Delta dentist's allowed fee (subject to $3000 lifetime max per person)		$500 copay + startup for normal 24 month treatment

*Members will be responsible for the difference if non-Delta dentists charge more than Delta's allowed fees.

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VISION PLAN FEATURES

	VISION SERVICE PLAN (VSP) VISION	
	IN-NETWORK	OUT-OF-NETWORK
PLAN BENEFITS		
COPAY	$15	
FREQUENCY Examination Frame Lenses Contact Lenses (in lieu of lenses)	Every 12 months Every 12 months Every 12 months Every 12 months	
EXAM *(Dilation when necessary)*	Covered in full*	$45 Allowance
STANDARD LENSES Single Vision Bifocal Trifocal	Covered in full*	$45 Allowance $65 Allowance $85 Allowance
FRAMES	$120 Allowance	$47 Allowance
LASER VISION CORRECTION (US LASER NETWORK)	Discounts at participating facilities	N/A
CONTACT LENSES: Elective Medically Necessary	$120 Allowance Covered in full	$105 Allowance $210 Allowance

*Vision exam is covered once every 12 months at the $15 copay. If a member requires lenses and has already paid the $15 exam copay, then an additional $15 is not required.

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PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) DISCLOSURE STATEMENT

This group health plan believes the Kaiser Permanente HMO Health Plan and the Blue Shield HMO Plan are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (714) 536-5917. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

SUMMARY OF MATERIAL MODIFICATIONS

Due to the recent Health Care Reform, the following changes have been made to the health plans effective January 1, 2011:

Coverage of Adult Children Up to Age 26 (applies to Blue Shield HMO, Blue Shield PPO, & Kaiser HMO Health Plans)
The Plans will offer an opportunity to enroll adult children for coverage under the Plans, subject to the following limitations:

- Coverage will be offered for children up to age 26.
- Children must be enrolled according to the terms of the Plans.
- Coverage of enrolled children will cease the first of the month following the month the dependent is age 26 unless applicable law requires us to offer coverage for a longer period of time.
- No coverage will be provided for adult children who are eligible to enroll in an eligible employer-sponsored health plan (only applies to Kaiser HMO and Blue Shield HMO Health Plans)

Limits on Preexisting Condition Exclusions (applies to Blue Shield HMO, Blue Shield PPO, & Kaiser HMO Health Plans)
The Plans' provisions relating to preexisting condition exclusions no longer apply for enrollees under age 19.

No Lifetime Limits on the Dollar Amount of Essential Health Benefits (applies to Blue Shield HMO, Blue Shield PPO, & Kaiser HMO Health Plans)
No lifetime limit on the dollar amount of essential health benefits will be imposed under the Plans. Non-essential health benefits may be subject to a lifetime limit on the dollar amount of such benefits. The Plan Administrator will determine whether or not a particular benefit is essential using good faith efforts to comply with a reasonable interpretation of the term "essential health benefits" as that term is described in the Patient Protection and Affordable Care Act.

(Continue on next page)

SUMMARY OF MATERIAL MODIFICATIONS (Con't)

Updated Appeals Process and New External Review Process (applies to Blue Shield PPO Health Plan)

(Portions of this new process will not be implemented until at least July 1, 2011)
A claim for urgent care will be reviewed as soon as possible, taking into account medical exigencies, but not later than 24 hours after receipt of a claim that contains sufficient information.

If you wish to appeal a denial of benefits or a coverage determination, you will be permitted to review your claim file and present evidence and testimony as part of the Plan's claims and appeals process. You will receive any new or additional evidence considered, relied upon, or generated by the Plan in connection with your claim. If the Plan intends to issue a final internal adverse benefit determination that is based on a new or additional rationale, the Plan will provide you with the rationale; and you will have an opportunity to respond prior to the final benefit determination. You will receive continued coverage pending the outcome of an internal appeal for certain claims that involve an ongoing course of treatment. You may be eligible to participate in an external review process in which your claim may be reviewed by an independent third party.

Preventive Health Coverage (applies to Blue Shield PPO Health Plan)
Subject to some limitations, the Plan will provide benefits for the following categories of in-network preventive health services ("Preventive Services") and will not impose any cost sharing with respect to such benefits:

- Evidence-based items or services that have in effect an A or B rating in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the guidelines supported by the Health Resources and Services Administration; and
- With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by the Health Resources and Service Administration.

Primary Care Provider & Pediatrician Designation (applies to Blue Shield PPO Health Plan)
Any enrollee in the Plan is permitted to designate any participating primary care provider who is available to accept him or her as a patient. With respect to coverage of a child, any physician (allopathic or osteopathic) who specializes in pediatrics may be designated as the child's primary care provider if the provider is in-network and is available to accept the child as a patient.

Coverage of Emergency Services (applies to Blue Shield PPO Health Plan)
The Plan's rules regarding coverage of emergency services have changed. Emergency services generally must be covered without any prior authorization, even if the services are provided on an out-of-network basis. They also must be covered without regard to whether the provider is a participating network provider. If the emergency services are provided out-of-network, the Plan cannot impose any administrative requirement or limitation that is more restrictive than ones imposed on in-network providers. The Plan also must follow new cost-sharing rules when emergency services are provided out-of-network. The services must be covered without regard to certain other terms and conditions (but not including some terms and conditions, including coordination of benefit provisions).

HEALTH CARE REFORM / REQUIRED FEDERAL NOTICES

IMPORTANT NOTICE OF OPPORTUNITY TO ENROLL CHILDREN WHO WERE PREVIOUSLY INELIGIBLE BY REASON OF A DEPENDENT ELIGIBILITY THRESHOLD (APPLIES TO MEDICAL PLANS ONLY)

This is to notify you that effective January 1, 2011 due to a change in applicable law, your children generally can be covered under the Plan until they attain age 26, regardless of their student or marital status and regardless of whether your home is their principal place of abode or whether you support them. Thus, children whose coverage under the Plan ended, who were denied coverage, or who were not eligible for coverage, because the availability of dependent coverage of children under the Plan ended before attainment of age 26 may be eligible for coverage under the Plan beginning January 1, 2011.

Coverage is not available to children who have attained age 26 or who will attain age 26 on or before January 1, 2011. Coverage is also not available to an adult child who is eligible to enroll in an eligible employer-sponsored health plan other than a group health plan of a parent (applies to Kaiser HMO and Blue Shield HMO plans only). In order for an adult child to be covered under the Plan, you must also be enrolled for coverage.

To request coverage for a child who has not attained age 26 as of January 1, 2011, or if you have any questions, please contact Human Resources at (714) 375-8456.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Your medical benefit plan may impose a preexisting condition exclusion upon enrollees age 19 and older. That means that if you are age 19 or older and have a medical condition before coming to our Plan, you might have to wait a certain period of time before the Plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period. Generally, this 6 month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6 month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy.

This exclusion may last up to 12 months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days.

To reduce the exclusion period by your creditable coverage, you should provide the new carrier with a copy of any certificates of creditable coverage (HIPAA Certificates) you have. If you do not have a Certificate, but you do have prior health coverage, you can obtain one from your prior plan or issuer.

Notice of Availability of HIPAA Privacy Notice

The Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we periodically remind you of your right to receive a copy of the HIPAA Privacy Notice. You can request a copy of the Privacy Notice by contacting Human Resources.

REQUIRED FEDERAL NOTICES

THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA) OF 2009

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan - as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in California, you may be eligible for assistance paying your employer health plan premiums. This information is current as of April 16, 2010. You should contact your State for further information on eligibility-

CALIFORNIA—MEDICAID
Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 866-298-8443

If you live outside of California, please contact either 877-KIDS-NOW or visit www.insurekidsnow.gov to find your State's information.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act (WHCRA) requires employer groups to notify participants and beneficiaries of the group health plan, of their rights to mastectomy benefits under the plan. Participants and beneficiaries have rights to coverage to be provided in a manner determined in consultation with the attending Physician for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the same deductible and co-payments applicable to other medical and surgical benefits provided under this plan. You can contact your health plan's Member Services for more information.

Important Notice from City of Huntington Beach About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Huntington Beach and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered and at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. City of Huntington Beach has determined that the prescription drug coverage offered by the plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan and drop your current City of Huntington Beach prescription drug coverage, be aware that you and your dependents will not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Huntington Beach and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

(Continue on next page)

For More Information About Your Options Under Medicare Prescription Drug Coverage...

Contact the office listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Huntington Beach changes. You also may request a copy of this notice at any time.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2011
Name of Entity:	City of Huntington Beach
Contact:	Human Resources
Address:	2000 Main Street, Huntington Beach, CA 92648
Phone Number:	(714) 375-8456

HELPFUL TIPS TO SAVE YOU TIME AND MONEY

Take Advantage of the Mail Order Pharmacy Benefit! Why go to the pharmacy if you don't have to?

Retirees who are enrolled in a Blue Shield HMO plan will have prescription drug coverage through Blue Shield Pharmacy. Retirees who are enrolled in a Blue Shield PPO plan will have prescription drug coverage through Medco.

If you are taking prescription medications on a regular basis, you may save time and money by using a mail order pharmacy. You may be able to receive a 90-day supply for 2 co-payments and your prescription is mailed directly to your home. Members save on out-of-pocket copay costs and shipping is free for standard postal delivery. Blue Shield HMO members can use Blue Shield's mail service pharmacy, PrimeMail, by calling (866) 346-7200 or visiting their website at www.blueshieldca.com. Blue Shield PPO members can use Medco by Mail by calling (800) 711-0917 or visiting their website at www.medco.com.

Having Surgery and/or X-Rays this Year?

If you are on the PPO plan, remember to ask your doctor if you are being referred to a Blue Shield -In-Network facility. Out of network hospitalizations are only covered at 60% and Blue Shield pays a maximum of $350 per day (out-patient) or $600 per day (in-patient). As always, verify that your surgery and/or x-ray has been pre-authorized by Blue Shield prior to your surgery and/or x-ray.

Prevention is the Best Medicine

- All retirees and family members should be receiving the preventive services recommended for their age and gender.
- Everyone with chronic conditions (hypertension, asthma, diabetes, etc.) needs to follow all recommended care prescribed by your physician.

My Dental Bills are Painful!

Dental bills can add up very quickly. If you are having dental work that will cost you more than $200 ask the dentist to get pre-authorization prior to the service. The insurance company will notify you if the procedure will be covered, how much *they* will pay, and how much *you* will be responsible to pay.

I Need HELP with My Insurance

Contact the customer service group for the appropriate carrier in the "Retiree Benefits Contact Information" Section or visit the City's internet site at www.surfcity-hb.org/retiree_benefits.

RETIREE BENEFITS CONTACT INFORMATION

Human Resources - Employee Benefits
- Internet: www.surfcity-hb.org/retiree_benefits
- Phone: (714) 375-8456, (714) 536-5213 or (714) 536-5917
- Fax: (714) 374-1743
- Email: bpratt@surfcity-hb.org
  jaymie.liu@surfcity-hb.org
  bcharles@surfcity-hb.org

CalPERS Retirement
- www.calpers.ca.gov
- (Group #0097)
  (888) 225-7377 or (888) CAL-PERS

Blue Shield (MEA, MEO, NA)
- www.blueshieldca.com/csac
- HMO Medical and Rx (Group #EH1009)
  (800) 642-6155
- PPO Medical (Group #E10055)
  (800) 642-6155
- PPO Rx through Medco Pharmacy (Group # E10055000)
  (800) 711-0917

Kaiser (MEA, MEO, NA)
- www.kaiserpermanente.org
- (Group #227450)
  (800) 464-4000

Dental
- www.deltadentalins.com
- Delta Dental/DPO (Group #4729)
  (888) 335-8227
- Delta Care USA (Group #1575)
  (800) 422-4234

Vision
- www.vsp.com
- (Group # 00105162)
  (800) 877-7195

PARS Retirement (Part-Time Employees)
- www.parsinfo.org
  (800) 540-6369

Due to privacy issues and concerns, we strongly recommend contacting your insurance provider directly with regard to claims, replacement/lost cards, or coverage questions.

Retiree Benefits Brochure designed and developed by

Alliant

in conjunction with the City of Huntington Beach, September 2010